Byford (H. T.)

UNUSUAL CASES OF ABDOMINAL SECTION.

BY

HENRY T. BYFORD, M.D.

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UNUSUAL CASES OF ABDOMINAL SECTION.*

By HENRY T. BYFORD, M.D.

Case I. *Abscess of the Gall-bladder Treated by Abdominal Section.*

I do not report this case because of its rarity, but because of the unusual interest connected with some of its features.

Mrs. Alice C., aged thirty-eight years, married thirteen years, six children, youngest two years, had an attack of pain in the region of the liver, two years ago, of so severe a character that she was unable to lie on the right side for several days. The pain was then more of an aching than of a colicky character. During the winter of 1890 and 1891 she had numerous attacks of colicky pain referable to the regions of the gall-bladder, but was better in the spring. June 4th, of this year, she had a severe attack of the same kind, accompanied by vomiting, since which time she has not been so well. At this time she first noticed a tumor about the size of an egg at the seat of the pain under the edge of the ribs. She has also had rheumatic pains in her left ankle, with occasional swelling of foot, since last winter.

October 15th, she came to my office, stating that she had just recovered from an attack of diphtheria, and that four of the children were down with it. She called my attention to a tumor a little below the margin of the ribs in the right hypochondriac region, that had been giving her trouble since her sickness. It looked about the size of the fist, but on counter pressure in the lumbar region was felt to extend back to the region of the kidney. I advised an exploratory incision. She went home feeling badly. The next day she was taken with severe pain in the tumor accompanied by vomiting and some temperature. October 19th, Dr. C. E. Caldwell, suspecting suppuration, introduced the point of a hypodermic syringe and drew out a few drops of pus. The pain increased, and her temperature marked 104 degrees F. I was called in consultation October 20th, P. M., and advised operation as soon as practicable. Four children in the adjoining room were convalescent with diphtheria. As she could not be removed, we had the front room prepared. Fumigation was not practicable on account of the cracks about the folding doors, on the other side of which were the family rooms and invalids. A sheet, wet with a five per cent. solution of carbolic acid, was the only protection from these cracks. The patient was too sick to be put in a bath-tub, so that the personal preparation of the patient was scarcely an ideal one.

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October 22d, assisted by Drs. C. E. Caldwell and J. T. Binkley, Jr., I cut down upon the mass, separated some slight parietal adhesions, and found that the liver and the lump formed one mass. By aspiration the pus was located and the parietal peritoneum stitched to the abscess walls. The tissue was friable and the sutures insecure, so I deferred opening it until adhesions should form. During the next twenty-six hours the patient passed less than six drams of urine, but by the use of saline diuretics and laxatives, counter-irritants and diaphoretics, the kidneys were finally brought to normal action. The vomiting, however, continued.

October 24th, I made a free incision in the abscess, evacuated the pus, and discovered gall stones in its interior. A drainage tube was inserted, and the nurse directed to wash out the cavity twice daily with warm water. The vomiting now ceased, and the patient began to have an appetite.

October 29th, nineteen gall stones were removed without much discomfort to the patient. The abscess, which proved to be the gall bladder, contracted rapidly and the patient rapidly regained her health. But the rheumatic inflammation of the left ankle joint became worse after the operation, and remained so, until Dr. Binkley, who conducted the after-treatment, put her upon salicylate of sodium, when it rapidly improved.

There are two or three interesting points connected with this case that induced me to report it. In the first place, the patient had recovered from diphtheria less than two weeks before the operation, and was taken from the infected rooms without a general bath, and without perfect isolation from the other diphtheritic cases. Second, the operation was done upon a patient with a high temperature. Third, almost complete suppression of the urine for twenty-six hours without bad after-effects. Fourth, the formation of an abscess following mild symptoms of hepatic colic, and the commencement of the signs of suppuration after an attack of diphtheria. Fifth, the division of the operation into three separate procedures, carried out at different times, viz. (1) cutting down upon and locating the abscess, and closure of the peritoneal cavity; (2) evacuation of the pus after the peritoneal cavity has been shut off by adhesions; (3) removal of the gall-stones after the general and local conditions had improved. In view of the condition of the patient and her surroundings, this cautious method of operation may, I think, be commended. Sixth, the association of localized rheumatic arthritis with the hepatic symptoms.

Recent experience with operations upon the gall bladder has shown that the danger is not any greater than other abdominal sections of equal extent. A. W. M. Robson has performed twenty-three

cholecystotomies without a death. It is now known that the gall bladder may be quite safely removed. The duodenum may be incised, and the calculus successfully removed through the duodenal end of the common duct (McBurney). Thornton has successfully incised and sutured the common duct, and has even left the gall bladder open in the peritoneal cavity without bad results. Successful operations may de done even under the most unfavorable circumstances, as was shown in the case reported this evening. All that has been wanting is a little better understanding of the technique. And with this understanding, it becomes our duty to operate upon cases of cholelithiasis of long standing, without waiting for inflammatory changes and suppuration which so often occur, and render a general rule of delay more dangerous than one of operative action. The time is at hand when we must cut down upon the gall bladder for conditions that are not immediately dangerous, in order to forestall serious results. It is my opinion that in all cases of lithiasis of long standing, attended by attacks of hepatic colic, or by accumulations of gall stones not evacuated in attacks of colic, we should make an exploratory incision and see what may be done.

Case II. *Ovarian Abscess in the Broad Ligament, Complicating Pregnancy. Subsequent abdominal Section. Ovarian Abscess of Twenty-five years standing.*

The following cases are interesting because they illustrate how well the system is able to take care of itself even under the most unfavorable condititons.

Mary B,, age twenty-five years, married two and a half years, had a child eighteen months ago, which was born asphyxiated at the end of a difficult and protracted labor. Was in bed five weeks with child-bed fever. Cervix and perineum both lacerated to a moderate degree. Four months after the confinement, she noticed a small tumor in the right ilio-vesical region, which has been there ever since, and was noticeable during her second and last pregnancy during the sixth and seventh months. There was some increase in the former slight soreness. Two months before I saw her, on a Sunday evening, at which time she was a little over seven months along, she had a chill followed by slight labor pains. About the same time the next evening she had another chill which was followed, in two hours, by the birth of a seven months child. The child was apparently healthy, and lived over two hours.

She did unusually well after this confinement, was up in a chair in one week, down stairs in ten days, able to dispense with her nurse in two weeks, and was around the house after that, feeling better than she had for months. The tumor has, however, been there ever since.

When she consulted me, two months after the last labor, I

was somewhat puzzled. I found a hard, rather insensible tumor the size of a goose-egg attached to the right side of the slightly enlarged uterus, just below the cornu. It felt like an old, thick-walled, ovarian abscess, but the history made me think it almost impossible. After a week's deliberation, I considered that the safest thing to do was to make an exploratory incision and clear up matters, particularly as I feared she might again become pregnant, and not fare so well as before. Her pulse was rather frequent, and her temperature, on some days, one degree above normal. Upon opening the abdomen four weeks ago I found an ovarian abscess developed in the upper part of the broad ligament, and attached to the side of the uterus a little below the Fallopian tube, over a space an inch and a half long, and a little over half an inch wide. A handful of omentum was gathered over it and firmly attached. On the other side, a cyst of the left ovary of about the same size burst under the gentle manipulation necessary to loosen it from its frail adhesions. I ligatured and cut off the omentum, and also the outer, thickened edge of the broad ligament. The abscess was peeled off and left a part of its wall on the uterus. This was curetted off until bleeding commenced. Then, an elastic ligature was thrown around the uterus lower down, the raw surface carefully pared and disinfected, and its edges drawn together by deep and superficial sutures. The elastic ligature was taken off, the left appendages removed, all oozing checked and the abdomen closed with drainage. The drainage tube was dry, and taken out in thirty six hours, and a piece of iodoform gauze inserted, and left for ten hours more. The patient so far had had no pain or temperature, and had taken no medicine. At the beginning of the fourth day the temperature went up to 102° F. Upon the removal of the stitch over the drainage hole twenty hours later, and the introduction of a probe, a sero-purulent fluid, with a slightly cadaverous odor, flowed out. The stitches in the uterus had evidently caused some necrosis. The infected area has since been irrigated three times daily with plain water —the odor was gone in two weeks, the cavity is closing, the temperature is normal, and the patient is sitting up and getting strong.

In this case, we have an ovarian abscess not interfering with impregnation, not undergoing any unfavorable changes during pregnancy, not interfering with pregnancy nor the condition of the child except to bring on labor at the beginning of the eighth month, and not influencing the puerperium in any way. The case illustrates also the value of drainage. The abdomen was dry after the operation, and the drainage tube evacuated but little bloody serum, yet without drainage the necrotic tissue would undoubtedly have quickly caused a fatal general peritonitis.

I do not think it is generally appreciated how often these old ovarian and tubal abscesses remain in the pelvis, lose their virulence, and exist for years without causing trouble. A year ago I saw a case of abscess almost precisely similar to this one in a woman over sixty years old, which must have been there since the birth of her youngest child, twenty-five years before. Yet this woman had considered herself in perfect health since the birth of that child as far as the pelvic organs were concerned, until just before I saw her, when she had over-taxed herself and brought on a slight but persistent uterine hemorrhage. This was one of those rare cases of uterine hemorrhage commencing so late in life not due to malignant disease nor tumor. It is needless to say that I counseled her not to allow a surgeon to rashly take from her what she had peaceably possessed for so long a time. She has concluded to keep it as long as she lives, and as a consequence is now enjoying the best of health.

Case III. *Abdominal Section in a Child Four Years and Eight Months Old for Sarcoma of the Ovary.*

Adelaide B. was born in March, 1887. She has always been rather a delicate-looking child of average size. She had a bloody flow from the vagina resembling menstrual discharge from September 16th to 24th, 1891. August 1st, one breast began to swell, and two weeks later the other. She had another similar vaginal discharge October 2d and 3d, and again October 20th to November 2d. During all of these times she complained of pains in the lower abdomen, and also took medicine from an eminent physician to check the flow, but without apparent effect.

I saw her first November 6th and found an oblong solid freely movable tumor about the size of a child's head lying across the abdominal cavity. The mammary glands were prominent, and dark-colored hair was growing on the pubes. On the seventh she was examined by another gynecologist, and on that evening was taken with severe abdominal pains and a temperature of one hundred and three fifths degrees F. On the tenth I saw her, and found the tumor increased almost to the size of a man's head. Localized peritonitis was present. The pains yielded promptly to opiates, and the tenderness had disappeared in a week. The tumor seemed a little smaller, but not so small as at my first examination.

November 22d I operated, with the assistence of Drs. Christian Fenger and J. T. Binkley, Jr. The tumor was spheroidal, and showed about half a twist of the pedicle, which was composed of the thickened and vascular broad ligament. An extravasation of blood had taken place in its distal end, causing inflammation and recent omental adhesions. The adherent omentum was amputated, the pedicle tied in the

usual manner, and the abdomen closed without drainage. The uterus was about the size of the thumb, and unusually vascular. The acute attack was probably occasioned by the twist in the pedicle.

The subsequent course of the case was an ideal one: the patient took no medicine except the citrate of magnesia, made but little complaint, and gave the nurses much less trouble than the average adult in similar conditions.

Case IV. *Ovarian Tumor in a Girl Thirteen Years Old.*

November 27th, I was consulted by Miss A., a young girl thirteen and a half years old, who had a multilocular ovarian tumor about the size of an adult head which could be palpated bimanually. The vagina readily admitted the finger, and the uterus seemed about normal in size. The breasts had begun to develop two years before, and occasional pelvic symptoms had occurred which seemed to the mother to point to attempts at menstruation, although no bloody flow had taken place. An abundant growth of dark, pubic hair came about the same time.

The chief points of interest in these cases seemed to be the enlargement of the breasts, growth of pubic hair, and signs of menstruation coming on prematurely in connection with the tumor, and probably as a result of its presence and growth. In the histories of ten other cases of ovarian tumor in children under the age of puberty, to which I had access, I find bloody flow from the uterus, or external signs of puberty, occurred in two. These, with my two cases, make four out of fourteen, or twenty-eight per cent., in which such signs or symptoms were noticed. Although these few cases cannot be taken as a fair representation of the general average, yet they point out the fact that such does not infrequently occur. And I should expect it to occur in solid or malignant tumors, or rapidly growing cystomata with short vascular pedicles; for in these we should have vascularity and development of the uterus, and increased functional activity in the local nervous centres. I would therefore regard it of diagnostic value.

There are about sixty such cases on record, in twenty of which an ovariotomy was performed with a mortality, as near as I can determine, of from twenty to twenty-five per cent. The main reason for the high mortality seemed to be the severity of the operation, due to waiting too long, and to the fact that children do not bear complicated and prolonged operations as well as older people. In ordinary, uncomplicated cases, I do not think that the mortality would be higher than with adults.

125 State Street.